Assembly Bill No. 248

CHAPTER 617

An act to add Section 1367.010 to the Health and Safety Code, and to add Section 10112.9 to the Insurance Code, relating to health care coverage.

[Approved by Governor October 8, 2015. Filed with Secretary of State October 8, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 248, Roger Hernández. Health insurance: minimum value: large group market policies.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014, and exempts health insurance coverage that provides excepted benefits from those reforms. PPACA requires each state to establish an American Health Benefits Exchange and allows qualified individuals to obtain premium assistance for coverage purchased through the Exchange. PPACA specifies that this premium assistance is not available if the individual is eligible for affordable employer-sponsored coverage that provides minimum value, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires that health benefit plans issued by health insurers and health care service plans in the small group market and the individual market comply with specified requirements. Existing law defines a health benefit plan for the purpose of health benefit plans issued by health insurers to exclude a policy or certificate of specified disease or hospital confinement indemnity if the insurer certifies to the commissioner that the policy is being offered as supplemental health insurance and not as a substitute for essential health benefits. Existing law requires an insurer issuing these policies in the small group market or the individual market to require that the persons to be covered are covered by coverage that is not designed to serve as supplemental coverage.

This bill would extend that requirement to a nongrandfathered health care service plan that offers, amends, or renews a group health plan contract and an insurer issuing a policy, except a health care service plan or insurer issuing a specialized health care service plan or policy, that provides less than 60% minimum value in the large group market and would require that the persons to be covered are also covered by a contract or plan that provides at least 60% minimum value. The bill would not apply to limited wraparound coverage, as described in a specified federal regulation, or a policy that

provides coverage for Medicare services pursuant to federal government contracts. This bill would exempt an insurer that is subject to specified disclosure requirements from these provisions. The bill also would not apply to certain grandfathered health insurance policies that provide basic health care services without annual or lifetime limits, as specified. By expanding the scope of an existing crime, with respect to the regulation of health care service plans, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares that an employee of a large employer who accepts health coverage from his or her employer that is less than 60 percent minimum value is barred by federal guidance from obtaining federal tax credits for affordable health coverage through Covered California.

(b) It is the intent of the Legislature in enacting this act to ensure that employees of large employers who are offered health coverage by their employers are offered coverage that meets or exceeds 60 percent minimum value, the minimum standard for comprehensive employer coverage under federal law. This requirement applies if an employer purchases that health coverage from a health plan or health insurer regulated by the State of California.

SEC. 2. Section 1367.010 is added to the Health and Safety Code, to read:

1367.010. (a) (1) A nongrandfathered health care service plan, except a health care service plan offering a specialized health care service plan contract, that offers, amends, or renews a large group health care service plan contract shall not market, offer, amend, or renew a large group plan contract that provides a minimum value of less than 60 percent.

(2) This section shall not apply to limited wraparound coverage, consistent with Section 146.145(b) of Title 45 of the Code of Federal Regulations.

(b) For purposes of this section, a plan shall provide a minimum value of at least 60 percent, as described in Section 36B(c)(2)(C) of the federal Internal Revenue Code and any regulation or guidance adopted under that section.

(c) The following definitions apply for purposes of this section:

(1) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a "small employer," as defined in Section 1357, 1357.500, or 1357.600.

(2) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

SEC. 3. Section 10112.9 is added to the Insurance Code, to read:

10112.9. (a) (1) Notwithstanding Section 10273.4, an insurer, except an insurer issuing a specialized health insurance policy, issuing a policy or certificate of health insurance, as defined in subdivision (b) of Section 106, shall not market, offer, amend, issue, or renew a large group plan contract that provides a minimum value of less than 60 percent.

(2) This section shall not apply to limited wraparound coverage, that is consistent with Section 146.145(b) of Title 45 of the Code of Federal Regulations. This section also shall not apply to a policy that provides coverage of Medicare services pursuant to contracts with the United States government.

(3) This section shall not apply to a grandfathered health insurance policy that provides basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, without annual or lifetime limits for any of the basic health care services.

(b) For purposes of this section, a plan shall provide a minimum value of at least 60 percent, as described in Section 36B(c)(2)(C) of the federal Internal Revenue Code and any regulations or guidance adopted under that section.

(c) This section shall not apply to an insurer that is subject to the disclosure requirements described in Section 10198.61.

(d) For purposes of this section, the following definitions apply:

(1) "Large group" means a group that is not a "small employer," as defined in Section 10753.

(2) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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